



Washington State
Department of Social
& Health Services

ODHH Office of the Deaf
and Hard of Hearing

OFFICE OF THE DEAF AND HARD OF HEARING (ODHH)
**APPLICATION FOR MEMBERSHIP ON THE
ODHH ADVISORY COMMITTEE ON DEAFNESS**

This form can be obtained electronically at <http://www.odhh.dshs.wa.gov>, or by calling the Department of Social and Health Services (DSHS), ODHH at (800) 422-7930 Voice/TTY.

Please return your completed application along with your resume to: DSHS Office of the Deaf and Hard of Hearing, PO Box 45301, Olympia WA 98504-5301.

APPLICANT INFORMATION

APPLICANT NAME		DATE OF BIRTH (MM-DD-YYYY)
MAILING ADDRESS		SOCIAL SECURITY NUMBER
MAILING CITY, STATE, AND ZIP CODE		COUNTY
PHYSICAL ADDRESS (IF NOT SAME AS MAILING ADDRESS)		COUNTY
PHYSICAL CITY, STATE, AND ZIP CODE (IF NOT SAME AS MAILING ADDRESS)		VIDEOPHONE NUMBER OR IP ADDRESS
(AREA CODE) AND TELEPHONE NUMBER Voice/TTY/TB <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Fax		
(AREA CODE) AND TELEPHONE NUMBER Voice/TTY/TB <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Fax		
EMAIL ADDRESS <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager		
ARE YOU A REGISTERED VOTER IN WASHINGTON STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No	STATE LEGISLATIVE DISTRICT	U.S. CONGRESSIONAL DISTRICT

Your Legislative District can be found on your voter identification card.

COMMUNICATION AND ACCOMMODATION

Hearing loss (check one)	Communication preference (check all that apply)
<input type="checkbox"/> Deaf	<input type="checkbox"/> American Sign Language (ASL) <input type="checkbox"/> Pidgin Sign Language (PSE)
<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Tactile (Deaf-Blind) <input type="checkbox"/> Cochlear Implant User
<input type="checkbox"/> Deaf-Blind	<input type="checkbox"/> Close up (Deaf-Blind) <input type="checkbox"/> Sign Exact English (SEE)
<input type="checkbox"/> Hearing/Speech Disabled	<input type="checkbox"/> Spoken Language <input type="checkbox"/> Oral/Lip-reading
<input type="checkbox"/> Hearing	<input type="checkbox"/> Other:

Reasonable accommodations (check all that apply)

<input type="checkbox"/> Sign Language interpreter	<input type="checkbox"/> TTY or Amplified Telephone
<input type="checkbox"/> Assistive Listening System (ALS)	<input type="checkbox"/> Support Service Provider (SSP)
<input type="checkbox"/> Computer Assisted Real-Time Transliteration (CART)	<input type="checkbox"/> Large print
<input type="checkbox"/> Written notes	<input type="checkbox"/> Braille – Grade 1
<input type="checkbox"/> Captioning – TV, DVD, VHS	<input type="checkbox"/> Braille – Grade 2

AFFIRMATIVE ACTION – TO MAINTAIN DIVERSE REPRESENTATION

The shaded grey area is optional.

GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	RACE OR ETHNICITY <input type="checkbox"/> Alaskan Native or American Indian <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Latino(a), Hispanic or Spanish <input type="checkbox"/> Other:
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EDUCATION AND EMPLOYMENT**Education**

HIGH SCHOOL

☐ Diploma ☐ Certificate ☐ GED

COMPLETION YEAR

HIGH SCHOOL NAME, CITY AND STATE

1. COLLEGE NAME, CITY AND STATE

GRADUATION YEAR

MAJOR OR SUBJECTS TAKEN

DEGREE

2. COLLEGE NAME, CITY AND STATE

GRADUATION YEAR

MAJOR OR SUBJECTS TAKEN

DEGREE

3. COLLEGE NAME, CITY AND STATE

GRADUATION YEAR

MAJOR OR SUBJECTS TAKEN

DEGREE

Current employment

OCCUPATION

EMPLOYER

(AREA CODE) AND TELEPHONE NUMBER

Previous employment

OCCUPATION

EMPLOYER

(AREA CODE) AND TELEPHONE NUMBER

MEMBERSHIP AND EXPERIENCE IN ORGANIZATIONS**Membership (professional, civic organizations, or government boards or commissions)**

ORGANIZATIONS

DATE OF TERM

TITLE

Community service or volunteer experience

ORGANIZATIONS

DATE OF TERM

DUTIES

SPECIAL SKILLS, STRENGTHS, AND INTEREST**Skills and strengths**

Do you have any special skills and strengths in (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Accounting/budget | <input type="checkbox"/> Program evaluation |
| <input type="checkbox"/> Fundraising/grant | <input type="checkbox"/> Legislation/lobbying |
| <input type="checkbox"/> Human resources/personnel | <input type="checkbox"/> Law, regulations, and policies |
| <input type="checkbox"/> Administration/management | <input type="checkbox"/> Leadership |
| <input type="checkbox"/> Public relations/media | <input type="checkbox"/> Other: |

SPECIAL SKILLS, STRENGTHS, AND INTEREST (CONTINUED)**Interest**

Do you have any particular interest in (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Families and children | <input type="checkbox"/> Housing | <input type="checkbox"/> Captioning |
| <input type="checkbox"/> Human and social services | <input type="checkbox"/> Court | <input type="checkbox"/> Interpreting |
| <input type="checkbox"/> Crisis intervention | <input type="checkbox"/> Medical | <input type="checkbox"/> Developmentally disabled |
| <input type="checkbox"/> Mental health | <input type="checkbox"/> Disabilities | <input type="checkbox"/> Recreation |
| <input type="checkbox"/> Diversity | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Drug and alcohol abuse |
| <input type="checkbox"/> Senior citizens/aging | <input type="checkbox"/> Education | <input type="checkbox"/> Technology |
| <input type="checkbox"/> Emergency notification | <input type="checkbox"/> Telecommunication relay | <input type="checkbox"/> Employment |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Entertainment | <input type="checkbox"/> Youth |
| <input type="checkbox"/> Government benefits | <input type="checkbox"/> Other: | |

QUESTIONNAIRE

Please answer the following questions. You may attach additional pages.

1. How did you learn about ODHH?
2. Why are you interested in serving on the ODHH Advisory Committee?
3. How will you share news or updates from ODHH with the community?
4. What are you goals for the community to remove barriers and/or improve quality of life?
5. Is there any factor which could cause a potential conflict of interest with your responsibilities as ODHH Advisory Committee member? Are you a staff or board member of any organizations that contract with ODHH?

Members are required to attend and participate in a minimum of four (4) meetings per year and participate in subcommittee or workshop activities. Members are expected to serve as a resource, be actively involved, and respond to mail polls and with local events. If appointed as a member, I will meet this commitment.

YOUR SIGNATURE

DATE

PRINT YOUR NAME HERE

TELEPHONE NUMBER (INCLUDE AREA CODE)

Please attach current resume.